APPLICATION FOR CALIFORNIA RESTAURANT MEALS ALLOWANCE

(Application for Optional supplemental Variation C – Independent Living Arrangement Without Cooking Facilities)

NAME *(Of Applicant/Recipient)*	**SSN** *(Of Applicant/Recipient)*

I/We am/are applying for the Restaurant Meals Allowance and understand that to be eligible, the following requirements must be met:

1) I/we do not receive meals as a part of my/our living arrangements, AND

2) Beginning ___/___/___ one of the following conditions exits:
(Enter date)

(Check one or more blocks that apply.)

☐ I/we do not have access to a working refrigerator or icebox.

☐ My/our cooking facilities are inadequate because I/we do not have access to: a working oven (regular or microwave) plus at least one temperature-controlled heating unit, or at least two temperature-controlled heating units (but no functioning oven).

☐ My/our cooking or food storage facilities are temporarily not working and are not expected to be working until ___/___/___
(Enter date)

I understand the California Restaurant Meals allowance ends with the month I receive meals as part of my living arrangement or I have access to adequate cooking and food storage facilities.

I agree to immediately notify Social Security Administration if there is any change in my living arrangement as described above.

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law and / or State Law. I affirm that all information I have given in this document is true.

SIGNATURE OF PERSON (S) MAKING STATEMENT	
Signature *(First name, middle initial, last name) (Write in ink)* **SIGN HERE** _____ **SIGN HERE** _____	**Date** *(Month, day, year)* ___/___/___ ___/___/___
Mailing Address *(Number and street, Apt. No., P.O. Box, Rural Route)*	**Telephone Numbers** *(include Area Code)* **Home** ( ) - **Work** ( ) -
City and State	**ZIP Code**

SSA Decision: ☐ Approved effective ___/___/___ ☐ Denied ☐ Notice of Planned Action provided ☐ Redetermination only			
By: *(Print Name)*	**Signature:**	**Title:** ☐ CR ☐ SR ☐ TE ☐ _____	**Date:**
Social Security Administration, American River Field Office, 5839 Manzanita Ave. Suite 6, Carmichael, CA. 95608			

Form SSAFO-E77-7527 (3/10/03)

Form Approved
OMB No. 0960-0045

SOCIAL SECURITY ADMINISTRATION

STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT	SOCIAL SECURITY NUMBER – –
NAME OF PERSON MAKING STATEMENT *(If other than above wage earner, self-employed person, or SSI claimant)*	RELATIONSHIP TO WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that -

1. What city are you primarily homeless in?
2. On average where can you be found (landmarks)?
3. What is your daily routine?
4. Where do you primarily sleep at night?
5. Do you have a mailing address? YES ☐ NO ☐
6. If yes, what is your mailing address?
7. If yes, what day do you pick up your mail?
8. Do you reside at this address? YES ☐ NO ☐

Please sign the back

Privacy Act Statement

Collection and Use of Personal Information

Public Law 110-328 and section 1631(e) of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to determine if you have made a good faith effort to pursue U.S. Citizenship, so that we may make a decision on additional Supplemental Security Income (SSI) benefits.

The information you furnish on this form is voluntary. However, failure to provide the requested information will prevent us from making a timely decision on your benefits.

We generally use the information you supply for the purpose of determining eligibility for benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1.To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage, including the U.S. Citizenship and Immigration Service in order to verify information provided;

2.To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3.To make determinations for eligibility in similar health and income maintenance programs at the Federal, state, and local level; and

4.To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.ssa.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PERSON MAKING STATEMENT

Signature *(First name, middle initial, last name) (Write in ink)*	Date *(Month, day, year)*
SIGN HERE ▶	Telephone Number *(Include Area Code)* ( ) -
Mailing Address *(Number and street, Apt. No., P.O. Box, Rural Route)*	
City and State	ZIP Code -

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

1. Signture of Witness	2. Signture of Witness
Address *(Number and street, City, State, and ZIP Code)*	Address *(Number and street, City, State, and ZIP Code)*